

Changing the Priorities in Public Health

By GEORGE JAMES, M.D., M.P.H.

THE HEALTH OFFICER is often asked to describe his formula for starting new programs and getting rid of old unproductive ones. This chapter in the art of public health includes more than program development and is considered here under the broader heading, "Changing the Priorities in Public Health." During this era of rapid change in program content, health officers are forced to employ this art to an unusual degree. The present discussion is offered with the hope that some public health practitioners may be aided by statements that reduce their daily problems to simple generalizations which have "deductive fertility."

Criteria for Determining a Priority

The establishment of priority is one of the major responsibilities of the health officer and provides tangible evidence of his capacity for leadership (1, 2). Before giving consideration to changing priorities, it would be well to list some of the criteria for establishing them.

Dr. James is director of health, Akron City Health Department, Akron, Ohio. He began his public health career in 1942 as assistant health officer in Williamson County, Tenn. In 1945, he began a decade of service with the New York State Department of Health and was serving as assistant commissioner for program development and evaluation prior to his present assignment. In addition, he has taught at the Yale University School of Medicine, Johns Hopkins School of Hygiene and Public Health, and the Albany Medical College of Union University. He presented this paper at the annual meeting of the Oklahoma Public Health Association, held November 9, 1955, at Stillwater.

Those listed below are suggested in part by Ascher (3, 4) and are illustrated by examples from the public health field.

Urgency. There is no doubt that the health problems created by a smallpox outbreak or a flood deserve top priority. A breakdown in one of our major barriers against communicable disease, or a mass debacle of any kind, must receive our immediate attention.

Feasibility. Often a program could be readily undertaken with existing resources if a slight amount of effort were added. The teaching of self-breast palpation to middle-aged women by public health nurses can be given priority as part of each visit to a new family under the generalized public health nursing program. Similarly, the use of the tuberculosis mass chest X-ray survey for the detection of heart disease is another example of an extra dividend program.

Scope. Will the program be of benefit to a significant number of citizens or only a few? Will it be countywide or only of value to one small area? It is obvious, for example, that higher priority will be given to a health education program on the early signs of cancer than one on muscular dystrophy.

Preparation for something more extensive. Dr. Ascher calls this the "multiplier effect." Some communities have developed a mobile physiotherapy unit to give simple treatments to home-bound patients with arthritis. This is deemed worthy of priority, since it is probably the first step in a more elaborate program of home care and rehabilitation for all varieties of chronic illness.

Coordination between existing programs. Several communities have invested heavily in programs of slum clearance and construction of low cost housing. Health units in those

areas can gear their environmental sanitation activities to make the total program more effective. The health officer is often able to provide the cement which integrates the vital community programs of other agencies. Many examples of this can be found in existing air pollution, hospital planning, and mental health programs.

Practicality. This is the old concept of efficiency. When the expected return on a small program investment is very great, it becomes a practical matter to give that program a high priority. In this category one can place fluoridation of the public water supply, since at an annual cost of about 10 cents per capita a two-thirds reduction in dental caries among children can eventually be achieved. Another example is the allocation of official funds for the treatment of cases of ringworm of the scalp because of the far greater community cost of the uncontrolled spread of this disease among school children.

Special ability or special mandate. By virtue of its unique skill or legal powers the health department is often the only one or the one best able to perform a particular service. The collection, tabulation, and analysis of morbidity and mortality data, the performance of health services for school children, and the development of inservice medical care programs in municipal government have fallen to the lot of some health officers. It would usually be impossible for a community to develop effective programs in these fields should the health officer fail to give them priority.

Good will. The performance of adequate health programs requires a background of community good will and support. Practically every health officer has, on occasion, given high priority to programs of low health importance as a matter of sound public relations. To avoid later confusion, the health officer should openly admit that the chief objective of such a health program is the enhancement of good public relations if that is the fact.

Changing the Priorities

The development of any health program requires attention to certain strategic factors in the community. With respect to any one pro-

gram, these factors are favorable or unfavorable to some degree. If entirely favorable, active service may begin immediately; if unfavorable, various subsidiary developmental steps must precede the large-scale program.

The physician who performed a "Smithwick" operation for the hypertensive disease of an influential State legislator was in a favorable position to promote a State hypertension commission. The availability of Federal funds for State industrial hygiene services during World War II resulted in the development of such divisions in the States that had not yet established them. Support for special case-finding programs among hospital admissions by local tuberculosis associations has sold these services to many communities.

The health officer who always waits patiently for the time when strategic factors become favorable can be said to be selecting his priorities on the basis of passive opportunism, that is, priority is given to something dramatic and successful, not necessarily that which is most needed to meet local problems. Such a health officer looks for and pounces upon the health angle of any general project that catches the community's fancy. This evokes that comparison between a statesman and a technician in public health (5), which may be applied to the opportunist. The opportunist in public health pursues fleeting, short-term, popular goals which are dramatic and sure of success; the statesman is not reluctant to lend his prestige to the struggle for those long-range goals which are greatly needed although temporarily neither popular nor feasible.

Lest one be tempted to develop a universal dislike for the public health opportunist, let him be advised quickly to correct that impression. Many of our excellent health programs in child health, medical rehabilitation, and research in chronic disease, owe their origin to a unique and happy combination of local factors. In fact, a health officer should be criticized for not taking advantage of such good fortune. Rather must the test of the practice of passive opportunism come from two other questions:

Having once seized the opportunity, has the health officer proceeded methodically and scientifically to build a firm and successful program, or has he dropped this one for the next fair

prospect which loomed into his jurisdictional field?

Is his total program a conglomerate of activities which arrived opportunely, or has he left his impact upon the field of public health practice through programs developed with a greater sense of his own responsibility for determination of priority?

The health officer of today expects to develop programs even when local strategic factors are not quite satisfactory. This chapter on the art of public health practice is the crux of our current task in the establishment of useful programs against the chronic degenerative diseases and accidents. Several examples will be considered to illustrate how priorities can be changed in the absence of perfection in local strategic factors.

The active opportunist. A health officer can act the opportunist even if there are no current opportunities. This might be dubbed "the program plan approach." This health officer sets many irons in the fire. When one of them gets hot, he steps in quickly and forges his program along the lines already planned. Instead of forcing a public reaction, the health officer needs merely wait for public opinion to force the program, which will be any of those he has been holding in readiness.

The danger of such an approach is, of course, that full many an excellent program may be "born to blush unseen." The health literature is replete with excellent program plans which read well but recount only an idea, not a blueprint for action which was effectively taken. After all, how does one judge a program plan which has never been translated into action?

Again, let the reader be assured that there need be no invidiousness attached to this technique of changing priorities. In fact, it is to be highly recommended for those programs which reason tells us are due for the touch of Midas. Health officers would do well to plan thoroughly in the field of adult rehabilitation, home care, radiological health, and mental health. Yet, once having planned, should we not do something more with our script than file it away until D-Day? If not, is there not the distinct danger that some other agency, presumably less well qualified than the trained health department, will seize the initiative be-

cause it happens to be more available to certain newly developing strategic factors?

The demonstration. Long an honored approach to the changing of priorities, the demonstration is usually characterized by its heavy accent on quality service. Less well recognized is the fact that the demonstration should be used only when the health officer is sure of his scientific and practical grounds. A demonstration, it should be remembered, can also be taken by our critics as proof that something cannot be done.

In developing the project, care should be taken to bite off no more than can be thoroughly chewed. If you are planning a complete and integrated school health demonstration program, do not try to establish it in your entire district. One census tract, one school, or even one classroom may be all you can handle effectively without compromising quality. The demonstration team must be overstaffed; later on is time enough to prove we can do the job or the major part of the job with less expense and personnel. Public relations skill is required and care must be exercised. The population involved can learn to consider themselves unhappily as guinea pigs, or with good public education, as those fortunate few who are privileged to receive the first chance to participate in an excellent program.

The demonstration approach is useful today for diabetes detection programs, heart disease detection by mass survey, prophylactic treatment of cases of rheumatic fever, and tumor diagnostic clinics. It, perhaps, should not yet be used for obesity control, which still seems to be based upon too much scientific conjecture to be predictable.

The research approach. The research project differs from the demonstration in one major respect: Its scientific basis is not yet considered proved. In fact, the central idea of establishing the project is to discover more scientific evidence, although it may also render good service to the study population. Our welfare colleagues have coined the term "service-linked research" as a fitting description of this method of program development (6).

The Albany Cardiovascular Health Center (7, 8) is a good example of this technique of changing priorities. The State civil service's

male population between the ages of 40 and 54 are receiving a complete periodic cardiovascular evaluation under a project established by the New York State Department of Health. Not only is this project stimulating fundamental research among the team who are members of the staff of the Albany Medical College or the State Health Department, but it is also aimed at:

- Evaluating the validity and reliability of techniques for the early diagnosis of coronary heart disease and hypertension.

- Stimulating an interest in heart disease among the staff of this State health department and encouraging them to add heart disease studies and related projects to their own specific programs.

- Giving the best in heart disease detection services to a "susceptible" population.

Similar projects are under way with respect to the study of highway accidents (9), prevention of first attacks of rheumatic fever among school children (10), and home accidents (11) in certain areas. At times this technique is used to iron out the administrative features of a program based upon fairly sound scientific principles. The term, pilot project, is commonly, but not exclusively, associated with this use. Such projects do not necessarily require the firm scientific base of a demonstration project.

The get-ready approach. Realizing that he wishes to reach a distant, still unattainable goal, the health officer may undertake a minor program which has a great multiplier effect. This brings him much nearer to coming to grips with the major problem.

In New York State, a program of control of shoe-fitting fluoroscopes was used as the first step in a complete program in radiological health (12). Noting the increasing scope of the problem of ionizing radiation, the department found that the relatively simple task of surveying and correcting the defective units among its 400 shoe-fitting fluoroscopes gave it the opportunity to:

- Acquire much data on the practical risks of ionizing radiation.

- Obtain equipment needed for radiological surveys.

- Stimulate citizen and staff interest in the problem.

- Develop inservice training, both academic and practical, for local health officers and sanitary engineers.

- Develop an extensive program plan, get additional staff, and obtain passage of a complete sanitary code chapter on radiological health.

The advisory committee. A problem such as radiological health, which touches many highly skilled professions, should be approached with the most expert advice. The available data must not only be accurate; it must be correctly interpreted. The implications of various control procedures must be appreciated and endorsed by the technical groups which are concerned. An advisory committee of leaders in these fields is essential.

The use of an advisory committee implies certain specific cautions over and beyond the obvious one of obtaining the proper personnel to serve:

- Do as much work as you can before they convene. You cannot afford false starts. These are usually busy people who cannot take the time to teach you fundamentals. Study the field well, send someone away for a special course if it is unfamiliar, and consult in advance with a key member of the committee to be sure you are on the right track.

- Send the material to be considered to each member well in advance, indicating your sources of information, and if possible, areas of special discussion and decision.

- If the group changes the first draft materially be sure that each has an opportunity to review and comment on the final draft.

The technique of the advisory committee has worked unusually well with new programs based upon the self-policing of special groups. Besides its use in radiological health, a State has found it of value in developing a program involving the labeling of household products which may be hazardous if improperly used (13). It has had an excellent trial in several areas for the development of programs of disaster control. Some health departments are now adopting the plan as a practical step toward good public relations in administration by having advisory committees of prominent citizens help define community needs and promote solutions.

The joint approach. Often a health officer can accomplish much by coordinating his efforts with those of another agency. His added increment of resources, though slight, may be precisely what is needed to make a worthwhile program a reality. At present, it is possible to work with cancer societies for the development of cancer registers, to tie diabetes surveys in with tuberculosis society mass X-ray programs, and to engage in rheumatic fever prophylaxis programs with heart associations.

In the use of this technique, the health officer is urged to spell out the details of the arrangement in writing. Such problems as the duration of the program, the extent of its evaluation, the next steps, the implications to other programs, are well worth some thought in advance. No health officer should permit his complete program to bog down due to firm, long-range commitments made to so many agencies that he has ended by relinquishing all rights to the determination of priority.

The advance on many fronts. Some health officers like to establish a balanced program of new activities; they insist upon having some entry that can be made under each category of public health activity. When something new arises, they do something about it, even if it is on a small scale. This is not a demonstration, not a well-planned approach, not research, not a pilot project, merely something to permit him to dabble lightly in a large variety of services.

If one mentions adult rehabilitation, this health officer reminds us that his public health nurses are following and attempting to return a few hemiplegics to self-sufficiency. If we bring up multiple screening, he has done some hemoglobin and diabetes tests at a county fair. If we mention home accidents, he had his statistician make a 2-month tabulation of patients treated at the emergency room of the local hospital and had a public health nurse follow up on a few of them.

Such public health dilettantism is not necessarily bad. It can be a good first step toward something better and, when this occurs, leads to the concept that there are really no new programs in public health, only changes in emphasis. Best of all, it is often the only way to cajole a reluctant staff. You can sell the care of Mrs. Fred Smith to a nursing division too

busy to accept a "program" in adult rehabilitation. You can get a sanitarian to check the lighting in an apartment hallway when the explanation of your plans for a sanitation home-accident program falls on deaf ears. Using this oblique approach, one can get a community to accept a worthwhile cancer program even before it realizes that something new had been added.

Unloading the Old Program

Since there are, to put it mildly, limitations to the resources available to local health officers, the addition of new programs means that "something's got to give." Health officers fear, and rightly so, to end programs precipitously. Such action may lead to a general feeling of impermanence and consequent lack of fervid local support toward public health programs. Nevertheless, old programs can be dropped under one of several methods:

Changing the character or purpose. The mass chest X-ray for tuberculosis will probably be used increasingly for heart disease and lung cancer detection while its original purpose declines in importance. The female clientele of a venereal disease clinic are easily available for cancer detection, particularly advisable since syphilis (14) and neglected cervicitis (15) are both considered to be precancerous lesions.

The knife. The development of modern knowledge about communicable disease control has permitted drastic changes in quarantine regulations and the free distribution of certain antitoxic serums. Occasionally, when available funds have been curtailed, health officers have found it feasible to do this (16).

Demonstration in reverse. A real challenge awaits local health officers who would like to explore methods of streamlining some of our traditional health programs. Evaluation studies on the details of prepasteurized milk inspection, water and sewage plant inspections, and some of the routines of school health practice might prove that much current effort could be curtailed. Perhaps better, quick-screening techniques could be employed to give warning of those places or persons requiring detailed individual attention. Such demonstration in reverse, in the sense that it shows how the efficiency of our programs may be improved by

curtailment, should result in the saving of effort which can then be diverted to more valuable services.

Plus-minus method. This method can also be called "accentuating the positive." By so doing, attention is drawn away from the unnecessary so that it can be de-emphasized. In milk-production control, one can accent cooling, clean equipment, and cow health, and allow cracks on the floor, area of window space, and certain required partitions to acquire less significance. Greater attention in cancer control can be given in some areas to teaching individual physicians how to perform cancer diagnosis rather than continue to multiply the number of expensive cancer detection clinics. In school health, the development of strong programs of teacher-nurse-parent conferences will draw attention away from unproductive, routine morning clinics.

Gradual attrition. Old programs which refuse to die might eventually fade away. County health units which have practiced rigid quarantine for certain common communicable diseases may hesitate to suggest a drastic change in keeping with modern control regulations. There is always the fear that any de-emphasis in control may spread to other disease programs. By avoiding all attempts at stimulating this particular program it can slowly wither until the community is better prepared to take a definite stand at modernizing quarantine regulations.

Summary and Conclusion

This discussion seeks to explore a small chapter in the art of public health practice dealing with the ways in which health officers add new services to their entire community health programs. Some of the criteria for the determination of priority are listed and certain principles presented to indicate how these priorities are changed. Examples of the development of new programs and de-emphasis of others are discussed. In general, we require two things of the modern health officer:

- Many individual approaches to public health practice.
- Precise and adequate communication on the plans and results of these practices.

From the mutual stimulation following the

defense of his activities before a jury of his peers will come progress not only in the science of preventive medicine but in the health officer's own very special art of public health practice.

REFERENCES

- (1) James, G.: Practical application of principles of health department planning to local tuberculosis control. *Am. J. Pub. Health* 40: 1219-1224, October 1950.
- (2) James, G.: Local health agencies in community welfare planning. *In* Social work in the current scene, selected papers, 77th annual meeting, National Conference of Social Work. New York, N. Y., Columbia University Press, 1950, pp. 42-51.
- (3) Ascher, C. S.: Program making in UNESCO, 1946-51. Chicago, Ill., Public Administration Service, 1951, pp. 21 and 64.
- (4) Institutes on Administration in Public Health—Part II. Program planning in public health, New York State Department of Health, Albany, N. Y.
- (5) Scheele, L. A.: Public health statesmanship. *Pub. Health Rep.* 68: 1-11, January 1953.
- (6) Maas, H.: Collaboration between social work and social sciences. *Social Work Journal* 31: 104-150, July 1950.
- (7) Hilleboe, H. E., James, G., and Doyle, J. T.: Cardiovascular health center. I. Project design for public health research. *Am. J. Pub. Health* 44: 851-863, July 1954.
- (8) James, G., and Hilleboe, H. E.: Evaluation during the development of a public health program in chronic disease: The Albany Cardiovascular Health Center. *Am. J. Pub. Health* 45: 140-150, February 1955.
- (9) Beadenkopf, W. G., Polan, A. K., Boek, W. E., Korn, R. F., and James, G.: An epidemiological approach to traffic accidents. *Pub. Health Rep.* 71: 15-24, January 1956.
- (10) Philadelphia points way for Nation in study aimed at rheumatic fever prevention. *In* American Heart Association News Release, October 14, 1955.
- (11) Wain, H., Samuelson, H. E., and Hemphill, F. M.: An experience in home injury prevention. *Pub. Health Rep.* 70: 554-560, June 1955.
- (12) Hilleboe, H. E., and James, G.: Research in program methods and evaluation in New York State. *Pub. Health Rep.* 70: 292-294, March 1955.
- (13) Levin, M. L., Kress, L. C., and Goldstein, H.: Syphilis and cancer: Reported syphilis prevalence among 7,761 cancer patients. *New York State J. Med.* 42: 1737-1745, September 1942.
- (14) Traut, H. F., and Benson, R. C.: Cancer of the female genital tract. New York, N. Y., American Cancer Society, 1954, p. 21.
- (15) James, G.: Facing up to budget cuts. *Am. J. Pub. Health* 44: 899-902, July 1954.